DOCUMENT RESUME

ED 379 881 EC 303 755

AUTHOR	Garland, Corinne W.; And Others
TITLE	Caring for Infants and Toddlers with Disabilities: New Roles for Physicians. Final Report.
INSTITUTION	Child Development Resources, Inc., Lightfoot, VA.
SPONS AGENCY	Special Education Programs (ED/OSERS), Washington, DC. Early Education Program for Children with Disabilities.
PUB DATE	31 Dec 94
CONTRACT	H024P10041
NOTE	58p.
PUB TYPE	Reports - Descriptive (141) -- Tests/Evaluation Instruments (160)
EDRS PRICE	MF01/PC03 Plus Postage.
DESCRIPTORS	*Disabilities; *Early Intervention; Family Practice (Medicine); Independent Study; Individualized Family Service Plans; Infants; *Inservice Education; Interdisciplinary Approach; Pediatrics; *Physicians; Professional Continuing Education; *Professional Development; Program Effectiveness; Team Training; *Teamwork; Toddlers
IDENTIFIERS	Virginia

ABSTRACT

The "Caring for Infants and Toddlers with Disabilities: New Roles for Physicians" program was designed to ensure that pediatricians and family physicians have the information and skills needed to participate fully in a Virginia statewide system of early intervention. An inservice training model was developed and field tested with approximately 200 physicians. The training curriculum included four levels: (1) introductory seminar; (2) self-study and technical support; (3) clinical application; and (4) communication and follow up. The curriculum focused on the role of the primary care physician on a community-based team engaged in a Child Find program, developmental evaluation and assessment, Individualized Family Service Plans, and transition. Using a "train-the-trainer" approach, a group of physicians was trained to teach the Introductory Seminar level as part of interdisciplinary teams composed of project staff, physicians, other early intervention providers, and parents. The remainder of the training was designed to be self-directed to the maximum extent possible, using self-study manuals and accompanying audiotapes as a major portion of the curriculum. Project products included a manual, four audiotapes, and evaluation measures. Program evaluation data support the efficacy of the model in increasing physicians' knowledge and competency as members of early intervention teams. Appendices include a sample seminar agenda, a listing of competencies, the self-study manual, and evaluation instruments. (DB)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
☑ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

ED 379 881

Caring For Infants and Toddlers with Disabilities: New Roles for Physicians

FINAL REPORT

Early Education Program for Children with Disabilities
U.S. Department of Education
Grant Number: H024P10041
CFDA: 84.024P

Corinne W. Garland, M.Ed.
Project Co-Director
Barbara A. Kniest, M.Ed.
Project Co-Director
Fran Gallagher, M.Ed.
Project Coordinator

Child Development Resources, Inc.
P.O. Box 299
Lightfoot, VA 23090
(804) 565-0303

December 31, 1994

BEST COPY AVAILABLE

EC 303755

II. ABSTRACT

Caring for Infants and Toddlers with Disabilities
New Roles for Physicians

An Early Education Program for Children with Disabilities Project

Corinne W. Garland, M.Ed
Executive Director/
Project Co-Director

Barbara A. Kniest, M.Ed.
Project Co-Director

Fran Gallagher, M.Ed.
Project Coordinator

Caring for Infants and Toddlers with Disabilities: New Roles for Physicians (CFIT) was designed to ensure that pediatricians and family physicians have the information and skills they need to be full participants in a statewide system of early intervention. The inservice training model which provides continuing medical education for physicians was developed in collaboration with the Virginia Academies of Pediatrics and Family Physicians and colleagues at the University of Virginia School of Medicine. The model was field tested with approximately 200 physicians representing all seven perinatal regions of Virginia.

The training curriculum was based on a set of competencies developed by the American Academy of Pediatrics and adapted by the project. The curriculum includes four levels: Introductory Seminar; Self-Study and Technical Support; Clinical Application; and Communication and Follow-Up. The curriculum provides information on the role of primary care physicians on community-based teams engaged in child find, developmental evaluation and assessment, IFSP's, and transition. Using a "train-the-trainer" approach, a group of physicians were trained to teach the Introductory Seminar level as part of interdisciplinary teams of project staff, physicians, other early intervention providers, and parents. The remainder of the training was designed to be self-directed to the maximum extent possible, using self-study manuals and accompanying audiotapes as a major portion of the curriculum.

Several products were developed by the project. Caring for Infants and Toddlers with Disabilities: A Self-Study Manual for Physicians is a 200 page manual which includes 10 sections with practice activities and supplemental readings. Four accompanying audiotapes on Child Find, Child Evaluation and Assessment, IFSP and Service Coordination, and Transition can be used as a preview or summary of the reading material. Knowledge and Competency Measures were developed to assist physicians in directing their study. These were also used as pre/post tests for measurement of change as a result of study. These products are available as resources to help physicians throughout the country become full participating members of early intervention teams.

CFIT evaluation data provide strong evidence of the efficacy of the model in increasing physicians' knowledge and competency as members of early intervention teams. Information about replication of the CFIT Model is available from Child Development Resources (804) 565-0303.

III. TABLE OF CONTENTS

IV. CFIT GOALS AND OBJECTIVES 1

V. THEORETICAL FRAMEWORK FOR PROJECT APPROACH 3

VI. DESCRIPTION OF CFIT MODEL 6

VII. PROBLEMS ENCOUNTERED 9

VIII. EVALUATION 10

IX. PROJECT CFIT IMPACT 20

X. FUTURE ACTIVITIES 21

XI. ASSURANCES 22

REFERENCES 23

APPENDICES

A. Sample Introductory Seminar Agenda

B. CFIT Competencies

C. Self-Study Manual Introductory Materials

D. Evaluation Instrumentation

IV. CFIT GOALS AND OBJECTIVES

GOAL 1: To coordinate project activities with state medical associations and with state and local agencies involved in planning or delivering early intervention services and personnel development systems.

OBJECTIVES

1.1 To coordinate project activities with the lead agency staff responsible for the Comprehensive System of Personnel Development (CSPD).
1.2 To coordinate activities with the Virginia Chapter of the American Academy of Pediatrics (AAP).
1.3 To coordinate activities with the Virginia Chapter of the American Academy of Family Physicians (AAFP).
1.4 To coordinate project activities with the Virginia Department of Health, Children's Specialty Services (Title V).
1.5 To coordinate project activities with local interagency coordinating councils, early intervention programs, and with the families they serve.

GOAL 2: To disseminate information about the project and its products to medical, early intervention, and personnel development constituencies.

OBJECTIVES

2.1 To develop project awareness information and materials.
2.2 To develop a dissemination plan in collaboration with state and local agencies involved in early intervention and with medical associations.
2.3 To disseminate appropriate awareness materials to selected targets.
2.4 To respond to requests for additional information regarding project services.
2.5 To present project information at selected state and national conferences.
2.6 To submit articles to selected medical and educational journals and newsletters.
2.7 To provide project information to other technical assistance or personnel development organizations or institutions.

GOAL 3: **To develop, package, and disseminate materials and products that support training in early intervention service delivery for physicians.**

OBJECTIVES

3.1 To review and refine competencies on which training is based.
3.2 To develop curriculum and materials for Level 1, Introductory Seminars and manual for Level 2, Self-Study.
3.3 To develop audiotapes for Level 2, Self-Study.
3.4 To develop materials for Level 3, Clinical Application and Technical Support.
3.5 To develop materials for Level 4, Communication and Follow-Up.
3.6 To package materials for dissemination.
3.7 To disseminate products to physicians.

GOAL 4: **To provide training and technical assistance to Virginia physicians leading to their increased participation in the early intervention service delivery system.**

OBJECTIVES

4.1 To select and train a group of pediatricians and family physicians to participate as members of interdisciplinary training teams.
4.2 To field-test training materials and procedures in a single perinatal region of Virginia.
4.3 To evaluate and revise training materials and procedures used in field test.
4.4 To provide training to community-based pediatricians and family physicians in six perinatal regions in Virginia.

V. THEORETICAL FRAMEWORK FOR PROJECT APPROACH

Congress, recognizing that the complex needs of infants and toddlers with disabilities cannot be met by a single discipline or agency, called for states to plan interagency, community-based, coordinated, family-centered systems of care through Part H of the Individual with Disabilities Education Act (IDEA) -- systems in which physicians' participation is essential. Physicians' offices are critical entry points to services designed to foster children's medical, social, and intellectual development (Pidcock, 1987). The opportunity for children and families to receive early intervention services is, to a large degree, dependent on physicians who are alert to a wide variety of developmental problems and are aware of where to find services needed by children and families (Scott & Garland, 1994). The physician is frequently the first of many professionals from whom parents seek advice when they have concerns about their child's development and whom they trust to provide information about their child's development (Scott & Garland, 1992).

Families have, for decades, reported the problems they have encountered when their physicians' referrals for early intervention have not been timely; when physicians have not fully shared information or perceived families as part of the decision-making process; when information and care have been provided without the emotional support families have needed; when physicians and health care are not integrated within the early intervention system.

There is little doubt on the part of medical and other early intervention professionals of the need for physicians to participate in the early intervention system at both the system

design and service delivery levels. The composition of state interagency coordinating councils (ICCs) across the country is evidence of the perceived importance of health care provider participation in designing the early intervention system. Physicians serve on state ICCs in 70% of the states (Wenger et al., 1989).

At the service delivery level, both legislation and recommended practice promote a strong role for health care professionals on the early intervention team. The comprehensive developmental needs of infants and toddlers with disabilities cannot be adequately addressed without also recognizing their medical/health and family support needs (Von Rembow & Sciarillo, 1993). The medical information a physician can provide to families and to other early intervention team members is often critical to the accurate assessment of children's development and an appropriate Individualized Family Service Plan (IFSP). Likewise, families and other early intervention team members can provide the physician with information regarding children's development that is a crucial component of routine health supervision. For children with severe disabilities and /or significant health impairments, the importance of this collaboration is heightened.

In order for physicians to assume their new roles as partners in providing community-based, interdisciplinary early intervention services, they must (1) be familiar with the provisions of Part H legislation, (2) understand the nature and importance of early intervention services, and (3) understand their role within the system of services (Wenger et al., 1989). However, the literature suggests that physicians are typically not prepared by their medical training with the knowledge and skills they need to be active participants in the early

intervention service system. In fact, despite initiatives by their professional organizations, many physicians remain unaware that Part H exists, let alone that the law has implications for their professional practice (Cohen, Kanthor, Meyer, & O'Hara, 1990). Blackman, Healy, & Ruppert (1992) described results of a statewide survey of pediatricians conducted by the New York State American Academy of Pediatrics (AAP) District II in which only 15% of the respondents felt well informed about Part H, and only 8% saw themselves as being involved in the development of IFSPs.

The CFIT model meets an urgent and compelling need perceived by parents, physicians, and other early intervention providers. The CFIT model of training is effective in increasing both pediatricians' and family physicians' knowledge and competency as members of early intervention teams.

VI. DESCRIPTION OF CFIT MODEL

The CFIT inservice training model developed in collaboration with the Virginia Academies of Pediatrics and Family Physicians and colleagues at the University of Virginia (UVA) School of Medicine provides continuing medical education for physicians to ensure that pediatricians and family physicians have the information and skills they need to be full participants in community-based systems of early intervention. The curriculum which was developed included four levels: Introductory Seminar; Self-Study and Technical Support; Clinical Application; Communication and Follow-Up. The model was developed and tested with 200 physicians in Virginia. The first two levels were developed by CDR and sponsored by the UVA School of Medicine.

A nomination process was used to select physicians to assume leadership roles during the regional Introductory Seminars. Families and physicians across the state nominated primary care physicians they felt provided exemplary medical care for children with disabilities and support for their families.

In order to accommodate physicians' busy schedules, Introductory Seminars were held in all seven of Virginia's perinatal regions. These regions represent a broad mixture of urban, suburban, and rural areas. Although the target audience was primary care physicians, specialists such as pediatric neurologists, developmental pediatricians, and neonatologists also participated in CFIT training. During the seminar (See Appendix A, Sample Introductory Seminar Agenda), an interdisciplinary team including 2 physicians, another early intervention

provider, and 2 parents introduce physicians to Part H legislation and to the concepts of a community-based, interdisciplinary, interagency, early intervention approach; to family-centered services; and to the self-study process. The seminar also provides an opportunity for physicians to meet Local Interagency Coordinating Council (LICC) representatives for the purpose of increasing awareness about community resources.

Physicians leave the Introductory Seminars with the self-study manual and accompanying audiotapes. The 200 page manual is based on competencies developed by the American Academy of Pediatrics and adapted by the project (See Appendix B, CFIT Competencies). These competencies address four components of community-based early intervention systems in which physicians will be called upon to play new roles as team members: Child Find, Assessment, IFSP, and Transition. The manual includes 10 sections with practice activities and supplemental readings (See Appendix C, Self-Study Manual Introductory Materials). The accompanying set of four audiotapes is used as a preview or a review of the information in the manual.

Following the independent study period, physicians have an opportunity to apply new knowledge and skills in their clinical practice with technical support from the project through a toll-free technical assistance support line. CFIT training has been approved by the University of Virginia (UVA) School of Medicine for 11 hours (3 hours for the seminar, 8 hours for self-study) in Category 1 of the Physician's Recognition Award of the American Medical Association. The UVA School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for

physicians. This continuing medical education activity has been reviewed by the American Academy of Pediatrics (AAP) and is acceptable for 11 AAP credit hours which can be applied toward the PREP Education Award available to Fellows and Candidate Fellows of the American Academy of Pediatrics. This program has been reviewed and is acceptable for 8 Prescribed hours by the American Academy of Family Physicians.

The follow-up training is designed to give participating physicians an opportunity to discuss their experiences during the Clinical Application period and to enhance their skills in communicating with families of infants and toddlers with special needs. Approximately 50 pediatricians and family physicians attended follow-up workshops at the annual meetings of the Virginia chapters of the American Academies of Pediatrics (AAP) and Family Physicians (AAFP). CFIT staff and physician consultants co-presented workshops entitled "Talking with Families of Infants and Toddlers with Disabilities". On their evaluations, physicians indicated that they would have "more patience", "more empathy", "would listen reflectively", and pay more attention to "parent input" as a result of the training. Articles about the presentation at the Virginia AAP meeting were published in Pediatric News and Family Practice News.

VII. PROBLEMS ENCOUNTERED

The project was originally titled "New Roles, New Skills: Competency-Based Inservice for Physicians". In response to physician suggestions, the project was renamed "Caring for Infants and Toddlers with Disabilities: New Roles for Physicians". This new title more clearly describes the focus of the grant activities.

The project encountered problems with physicians not returning their post evaluation measures. In retrospect, project staff feel that this return rate would have been greatly increased if reminders had been sent on Academy of Pediatrics or Family Physicians letterhead as was much other project correspondence.

The project overestimated the percent of participants who would attend the annual meetings of their academies. In response to these physicians and to others who expressed interest in CFIT but were unable to attend either the Introductory Seminar or the Academy meetings, project staff offered the opportunity to participate in the self-study component only. During the Outreach project, the evaluation consultant will be asked to compare data related to this group with those of the group that completed all components.

VIII. EVALUATION

The CFIT model of inservice training is designed to increase pediatricians' and family physicians' knowledge and competency in four areas of early intervention services in which physicians will be called upon to play new roles as members of community-based, interagency early intervention teams: Child Find, Assessment, IFSP, and Transition. The evaluation was designed to assess changes in participants' knowledge and in their measurement of their own competence to fulfill the roles that the training defined. The confidential nature of the physician-patient relationship makes observation of those skills in the setting of medical care inappropriate for this project.

The efficacy of the CFIT model of physician training was evaluated based upon the results of training two groups of physicians. Initially, a group of 19 physicians was nominated by families of children with disabilities to take part in the training because of what parents described as their "exemplary" care for children with disabilities. This group will be referred to as the Leadership Group. While this was a small and select group of participants, the project staff and evaluators reasoned if CFIT resulted in improvement in the knowledge and competencies of this group which might be expected to have high baseline levels of knowledge, then the CFIT model could be expected to have an even greater impact on other physicians who might be expected to have lower baseline levels of knowledge.

The second set of 28 completed sets of pre- and post-training evaluation instruments came from 124 physicians who participated in Regional Introductory Seminars and the Self-

Study Program. This group will be called the Regional Training Group. One hundred-one (101) physicians completed their pre-evaluations, 28 completed both pre- and post-training evaluations. Problems in obtaining post-tests following self-study are discussed on page 9.

To determine the efficacy of the model, three sets of questions were asked concerning (1) the extent to which training increased physicians' knowledge about early intervention services; (2) the extent to which training increased physicians' competence to fulfill their roles as members of early intervention teams; and (3) the extent to which training content and materials were perceived as useful and of high quality by the participants. Data providing strong evidence of the model's efficacy are summarized below.

Extent of Increased Physician Knowledge About Early Intervention Services

The Physician Knowledge Measure was designed to assess physicians' knowledge in the four areas of early intervention services. These areas were Child Find, Assessment, IFSP, and Transition. The measure consisted of 15 multiple choice questions.

The pre- and post-training scores for both the Leadership Group and the Regional Training Group are presented in Table 1. It was not possible either to make comparisons between these groups directly or to merge the data from the two groups. The initial evaluation of the Leadership Group did not code the data in a way that an individual's pre- and post-tests could be associated. Thus, it was necessary to analyze the data from the Leadership Group using between groups t-tests, rather than the more powerful and appropriate matching-pairs t-tests. The important thing is that having used a less powerful statistical test,

TABLE 1

RESULTS OF PRE VS POST- KNOWLEDGE MEASURE

Groups	Pre-test x (SD)	Post-test x (SD)	t	
Leadership Group	69.4(13.4)	85.4(7.9)	-3.98	P<.001
Regional Training Group	57.4(13.5)	74.6(8.0)	-6.14	P<.001

one can be assured that significant results are indeed significant. For this reason, the Leadership Group's and Regional Training Group's scores are presented separately.

Before the training, Leadership Group participants scored 69% correct on the *Physician Knowledge Measure*. The post-training scores showed a statistically significant increase to 85% correct. This change represents 23% increase in physicians' knowledge and indicates that CFIT training resulted in increased physician knowledge about family-centered early intervention services for children with disabilities.

Before training, the Regional Training Group participants scored 57% correct on the *Physician Knowledge Measure*. The post-training scores showed a statistically significant increase to 75% correct. This change represents a 32% increase in physicians' knowledge and further indicates that CFIT training resulted in increased physician knowledge about family-centered early intervention services for children with disabilities.

Analysis of the scores of both the Leadership Group and the Regional Training Group on the Child Find, Assessment, IFSP, and Transition sub-scales indicated that increases occurred in all areas, with significant knowledge gains in the areas of Child Find and Assessment for the Leadership Group and in these areas and IFSP for the Regional Training Group. These results are represented in Figure 1.

The Regional Training Groups' scores on the *Physician Knowledge Measure* have also been graphically represented as distributions, comparing the distribution of pre-training and post-training scores (Figure 2). Fifty-four percent (54%) of the participants scored 60% or

PRE- VS POST KNOWLEDGE MEASURE

Leadership and Regional Training Groups

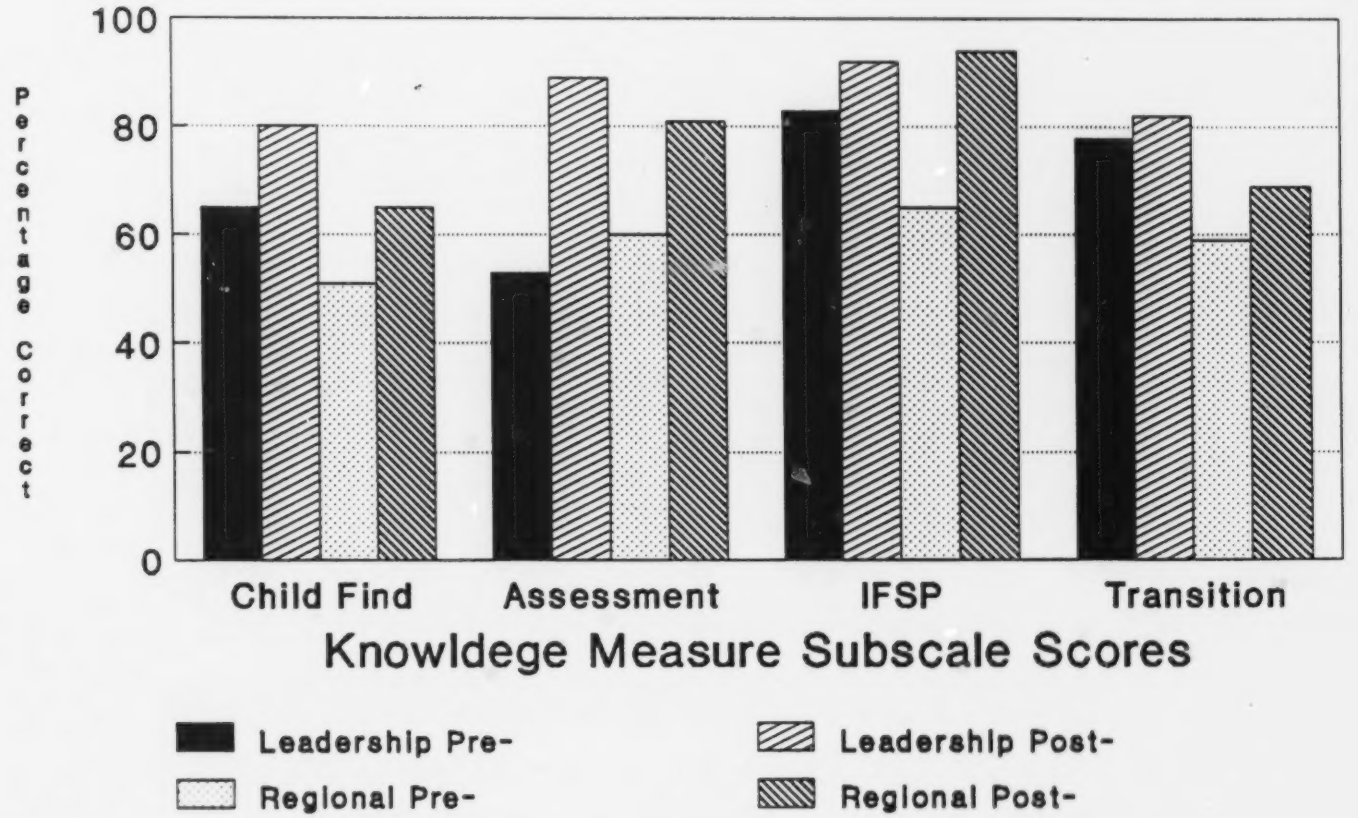


FIGURE 1

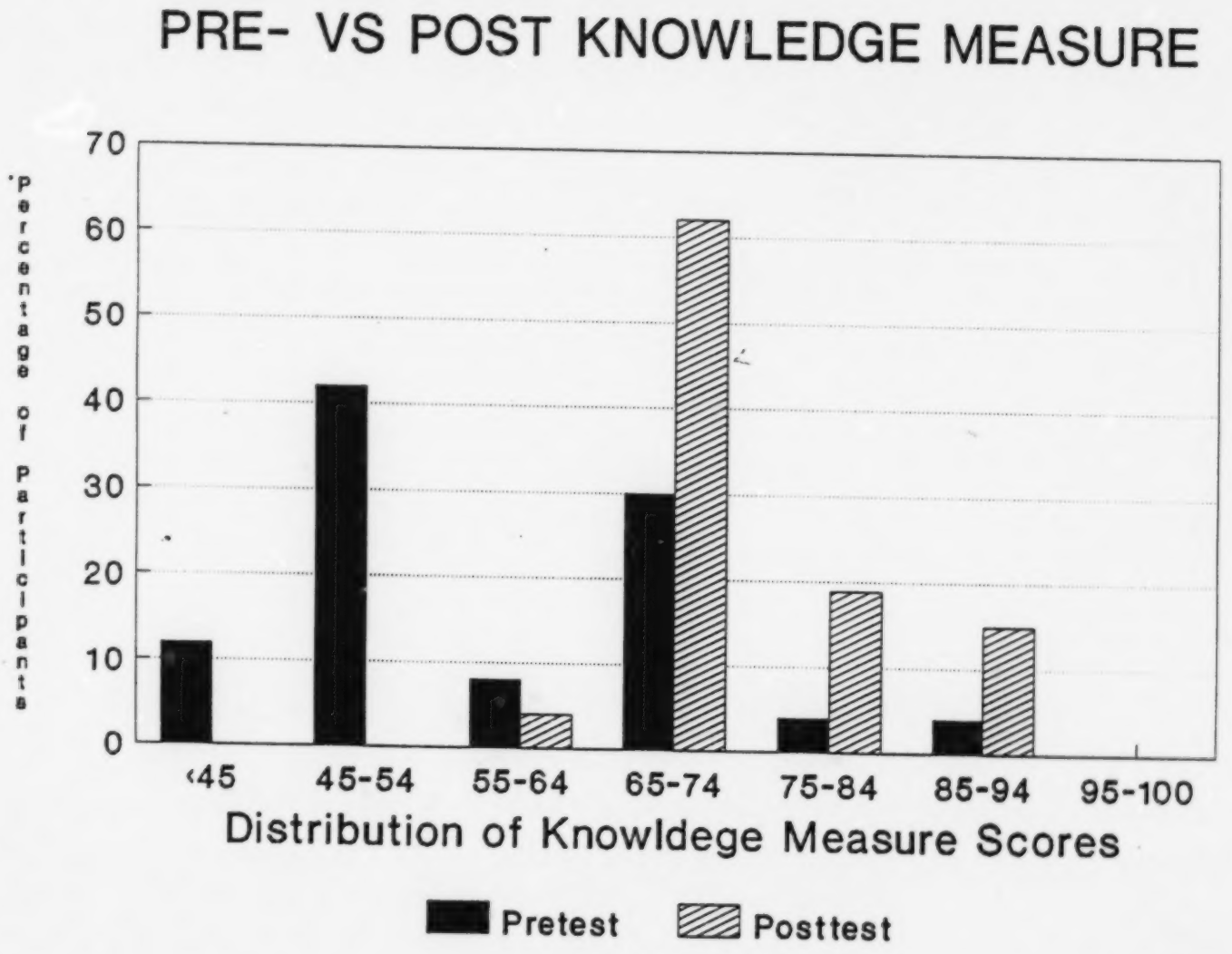

PRE- VS POST KNOWLEDGE MEASURE
Percentage of Participants
70
60
50
40
30
20
10
0
<45
45-54
55-64
65-74
75-84
85-94
95-100
Distribution of Knowldege Measure Scores
Pretest
Posttest

FIGURE 2

below on the pre-test, while no participants scored below 60% on the post-test and 96% of the participants scored 65% or better.

The results on the *Physician Knowledge Measure* provide strong evidence of the efficacy of the CFIT model of inservice training. First, in both groups, initially there were large deficits in important knowledge about services for children. This deficit was reduced by 50% in the Leadership Group and 42% in the Regional Training Group by participation in the Introductory Seminar and Self-Study process. In addition, the proportion of Regional Training participants scoring below 60% on the knowledge measure was reduced from 54% to zero by CFIT training. The project was thus able to increase significantly the knowledge of both physicians with great amounts of previous experience with children with disabilities and those with relatively less experience and knowledge of this specialized field.

Extent of Increased Physician Competency

The Physician Competency Measure examined physicians' perceptions of their own competence as members of the early intervention team. The physicians rated their competence on 44 items related to the four sub-domains of Child Find, Assessment, IFSP, and Transition. Competencies were adapted from those developed by AAP (AAP, 1988). Each item consisted of a 5 point Likert-type scale, with 1 being "I need a great deal more information on training", 3 being "I need some more information on training", to 5 being "I have full mastery". Analysis of these data indicated that the project increased the Leadership Group physicians' perceived competence from 3.7 before the training to 4.3 after the training

and increased the Regional Training Group's perceived competence from 2.7 before the training to 3.9 following training. These results are represented in Table 2. Analysis of the Child Find, Assessment, IFSP, and Transition sub-scales of the competency measure indicated that the pre- vs post-training differences were significant for both physicians' groups and for all four sub-scales (Figure 3). Again, the CFIT model of inservice training increased physicians' measure of their competence to fulfill their important role in early intervention for children.

Introductory Seminars and Self-Study Program: Extent to which Training Content and Materials were Perceived as Useful and of High Quality

The Regional Training Group physicians participating in the CFIT model of inservice training completed two rating scales: *The Introductory Seminar Evaluation*, designed to rate the quality and usefulness of the Introductory Seminar, and *The Self-Study Manual and Audiotapes Evaluation*, to rate the quality and usefulness of these materials. One hundred twenty-four (124) physicians participated in the Regional Seminars and Self-Study Program. Of the 124, 43% are pediatricians, 42% are family physicians, 5% are "others" (e.g. pediatric neurologist) and 10% did not indicate their primary position.

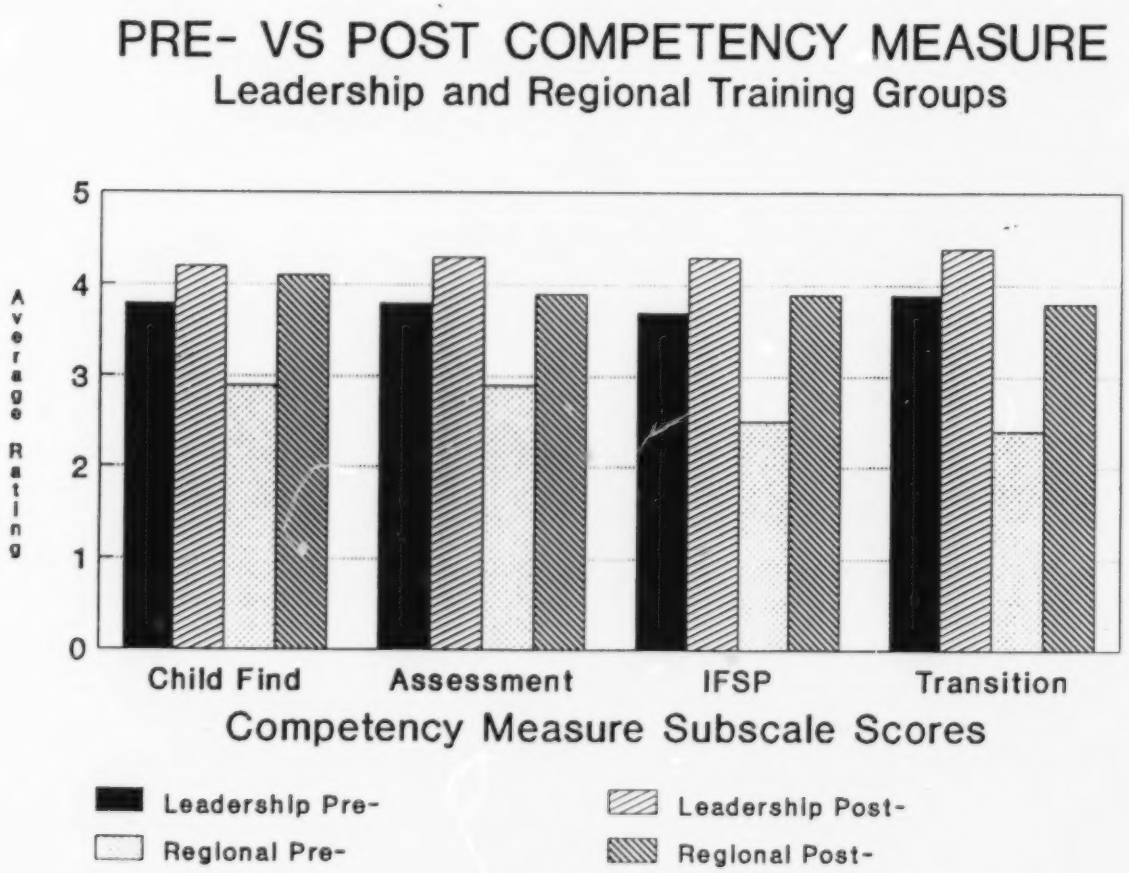
When asked the value of panelist presentations (using a Likert-type scale: 0 = poor to 4 = excellent) regarding child find and assessment, participants (n = 107) rated both the overall value and value of the discussions generated as very good to excellent (82%). Respondents rated the overall value of IFSP and transition as very good to excellent (83%)

TABLE 2

RESULTS OF PRE V POST COMPETENCY MEASURE

Groups	Pre-test x (SD)	Post-test x (SD)	t(df=27)	
Leadership Group	3.71(.59)	4.29(.50)	-2.90	p<.01
Regional Training Group	2.7(.81)	3.9(.67)	-10.13	p<.01

FIGURE 3



and the value of the discussion generated as very good to excellent (84%). Almost all (97%) respondents (n = 103) evaluated the seminar approach as an effective way of learning.

Self-Study Manual and Audiotapes evaluations were included in the post evaluation packet. Twenty-eight (28) physicians returned all 3 instruments, 1 returned only the manual evaluation. Ninety-seven percent (97%) (n = 29) found the information in the Self-Study program clear, 87% rated the information as useful, and 87% reported that the curriculum met their expectations. Eighty- six percent (86%) (n = 29) of the responding physicians noted that they would recommend this program to a colleague. These ratings indicate a high degree of satisfaction with the quality and usefulness of the CFIT model of inservice training and materials.

The following statements summarize CFIT model efficacy:

- CFIT training results in increased physician knowledge about family-centered early intervention services for children with disabilities.
- CFIT training, was effective for physicians who already have interest and experience in providing care for children with disabilities, and also is effective for physicians with less previous interest and experience in this area.
- The CFIT model of inservice training increases physicians' competence to fulfill their important role in early intervention for children.
- Physicians indicate a high degree of satisfaction with the CFIT model of inservice training and perceive the training content and materials to be useful and of high quality.

IX. PROJECT CFIT IMPACT

The following 2 comments from Introductory Seminar team members indicate the significant impact that the CFIT training had on community-based physicians involved in providing services to children with disabilities:

> "Thank you very much for allowing me to participate in the seminar. I learned a lot more than I contributed. Many physicians came up to me later and said that it totally opened their eyes as to the potential of what they could do and the help they could get."
>
> ***(Physician Team Member, 1994)***

> "During the break and at the conclusion of the seminar, several physicians expressed to me that they had gained not only new information, but new insights that were going to change the way they practiced medicine."
>
> ***(Early Intervention Provider Team Member, 1994)***

The CFIT Project has contributed to current knowledge and practice by providing families, physicians, the early intervention system, and the professional community at large with:

- a successful and replicable model of inservice training for physicians that results in increased knowledge and competence regarding the role of the physician in community-based, family-centered, early intervention services,
- a model of continuing education for physicians that is individualized, self-paced, and self-directed,
- a model of inservice training that meets the continuing education standards of the medical community with approval for 11 category 1 (the highest level attainable) CMEs by the University of Virginia School of Medicine and the American Academy of Pediatrics and 8 Prescribed hours by the American Academy of Family Physicians, and
- curricula and materials that include a Self-Study Manual and accompanying audiotapes that can be customized for use by other states throughout the country.

X. FUTURE ACTIVITIES

A major focus of future activities will be on replication of the CFIT model of training. Child Development Resources has been awarded a three-year outreach grant to replicate the CFIT model in other states. The project, CFIT Outreach, will assist state leadership groups in using the CFIT model to increase the involvement of physicians in community-based early intervention systems.

XI. ASSURANCES

This statement serves as an assurance that the required number of copies of this final report have been sent to the Office of Special Education Programs, U.S. Department of Education and to the ERIC Clearinghouse on Handicapped and Gifted Children. In addition, copies of the title page and abstract have been sent to the other addresses as requested.

REFERENCES

American Academy of Pediatrics (1988, Nov.). Proceedings From A National Conference on Public Law 99-457: Physician Participation in the Implementation of the Law. Washington, D.C.

Blackman, J. A., Healy, A., & Ruppert, E. S. (1992). Participation by pediatricians in early intervention: Impetus from Public Law 99-457. Pediatrics, 89 (1), 98-102.

Cohen, H., Kanthor, H., Meyer, M.R. & O'Hara, D. (1990). American Academy of Pediatrics Survey: District II. The Mental Retardation Institute, New York Medical College, Valhalla, N.Y.

Pidcock, F.S. (1987). Developmental screening techniques for pediatricians. Pediatric Basics, 47, 7-11.

Scott, F. & Garland, C. (1992). "Assessing and Remediating Pediatricians' Needs in Early Intervention." Early Childhood Report. LRP Publication, April (P.14-16).

Scott, F. & Garland, C. (1994). What Do Physicians Want to Know? Statewide Survey Report of Physicians' Needs for Early Intervention. In R. Darling & M. Peters (Eds.), Families, Physicians, and Children with Special Health Needs; Collaborative Medical Education Models. Westport, CT: Greenwood Publishers.

Von Rembow, D. & Sciarillo, W. (Ed.). (1993, June). Nurses, Physicians, Psychologists, and Social Workers Within Statewide Early Intervention Systems: Clarifying Roles Under Part H of the Individuals with Disabilities Education Act.(1st ed.). Bethesda, Md.: Maryland Infants and Toddlers Program & Association for the Care of Children's Health

Wenger, M., McLauren, J., Guild, P., Loda, F., Gallagher, M., DeFriese, G., Rich, L., & Bergsten, C. (1989). Physician involvement in planning for P.L. 99-457 Part H: Interagency coordinating council roles and systems planning issues. Chapel Hill, NC: Carolina Institute for Child and Family Policy.

APPENDIX A

Sample Introductory Seminar Agenda

"Caring for Infants & Toddlers With Disabilities: New Roles for Physicians"
SEMINAR

Community Hospital of Roanoke Valley
Roanoke, Virginia

December 1, 1993
6:00 - 9:00 pm *

A G E N D A

6:00 - 6:15	**Registration**
6:15 - 6:30	**Welcome and Introduction**
6:30 - 6:45	**Philosophical Foundations** **Role of MD in State/Local Planning and Advocacy**
6:45 - 7:30	**Interdisciplinary Panel Addressing** **Child Find & Assessment**
7:30 - 8:00	**BREAK/ MEET COMMUNITY PROVIDERS**
8:00 - 8:45	**Interdisciplinary Panel Addressing** **IFSP & Transition**
8:45 - 9:00	**Evaluation/Wrap Up**

* **Dinner will be provided.**

APPENDIX B

CFIT Competencies

CARING FOR INFANTS AND TODDLERS WITH DISABILITIES: NEW ROLES FOR PHYSICIANS

COMPETENCIES ON WHICH CURRICULUM IS BASED AND PAGE REFERENCES TO CORRESPONDING SECTIONS OF THE MANUAL

A.	CHILD FIND	PAGE REFERENCES
	The primary care physician will:	
1.	display an awareness of the importance of developmental and family issues	pp. 21-29
2.	know the components and intent of P.L. 99-457 and the policies and procedures of their state relative to screening, identification, and referral of children to Part H services	pp. 39-44, 47-55
3.	know the criteria for eligibility within their state for Part H services.	pp. 52-55, 99-100
4.	be able to identify factors placing a child at-risk for developmental delay with particular emphasis on those factors making a child eligible for Part H services	pp. 52-55, 62-67
5.	have and regularly employ strategies in a variety of settings (e.g., newborn nursery, hospital stays, well-child office visits) for the observation and identification of children who have disabilities, developmental delays, or who may be at-risk for delay	pp. 63-69
6.	be skilled in the use and interpretation of developmental screening techniques	pp. 69-74
7.	have a strategy for providing periodic screening in the context of office-based primary care including a. developmental screening of all infants; and b. periodic rescreening for all children.	pp. 63-69
8.	know and use the procedures for referring infants and toddlers to the Part H services within the community, and know the variety of community resources available for infants and toddlers who may be eligible	pp. 75-82 Appendix B
9.	have and regularly use a variety of strategies to enhance linkages and coordination of care including making and receiving referrals to and from secondary and tertiary care settings, risk registries, and other relevant consultants	pp. 68-69, 78-82, 92, Appendix B
10.	have and regularly use a variety of strategies for increasing family awareness of developmental milestones, resources for assessment, the importance of early identification, potential for improved outcomes	pp. 63-68, 74-75
11.	have and regularly use a variety of formal and informal interview techniques to elicit family concerns and observation regarding the development of their infants and toddlers	pp. 64, 71, 130-143

A.	CHILD FIND (Continued)	PAGE REFERENCES
12.	have and use communication skills and strategies appropriate for ensuring family understanding of medical information, including consultant findings, and for ensuring their involvement in decisions about referral to Part H or further evaluation and intervention	pp. 74-77, 86-91
13.	have strategies and routines for the acquisition of new state of the art knowledge base related to this area	pp. 83-85 toll-free number

B.	ASSESSMENT	PAGE REFERENCES
	The primary care physician will:	
1.	be aware of options for his/her own involvement in assessment, diagnosis, and management of the child's health needs based on interests and skills, and be able to communicate clearly that degree of involvement to parents or caregivers	pp. 103-104
2.	be skilled in interpreting diagnostic information and implications of diagnosis with family, including eliciting their ideas and concerns	Preface, pp. 113-116, 121-127
3.	know and use resources for obtaining consultation from other Part H providers necessary and be skilled in presenting need and rationale for consultation to family	Appendix B
4.	be able to interpret all findings for the family in an understandable way and involve and support family in decisions related to additional assessment, referral, and intervention	pp. 97-98, 113-116
5.	be able to perform longitudinal monitoring of a child to clarify trends of growth or function, when appropriate	pp. 63-69, 98-104
6.	be able to provide family with options for referral and to make appropriate referrals to agencies providing needed services	Appendices B & C
7.	be able to present information related to the child's medical condition and functional level to family and other team members responsible for development of a plan of intervention	pp. 103-104
8.	be skilled in formal and informal interview techniques to allow families to share their strengths and needs related to their child's development and provide emotional support in the process	pp. 97-98, 105-107
9.	be skilled in formal and informal interview techniques that encourage families to share their own perceptions of their child's problems, strengths, and needs, and that help families clarify those perceptions	pp. 111-112, 113-117, 135-140
10.	be aware of community resources and have skills in helping families obtain the services they desire	Appendices B & C

BEST COPY AVAILABLE

C.	DEVELOPING AND IMPLEMENTING IFSPs	PAGE REFERENCES
	The primary care physician will:	
1.	be aware of P.L. 99-457 and of principles of family-centered intervention plans	pp. 24-25, 41-42, 145-146
2.	be able to define and arrange medical consultations required for the child's assessment, diagnosis, and ongoing management in a manner consistent with the self-selected degree of involvement and to maintain communication with consultant	pp. 148-150, 169-170
3.	know and be able to discuss with a family the value of an IFSP, and know how to initiate or help a family initiate a group process to begin IFSP development	pp. 145-150
4.	assist family in determining who should be involved in the IFSP process	pp. 147-148
5.	know the procedure for referral to local early intervention service provider(s) responsible for IFSP development and help family in arranging for their participation	pp. 75-82 Appendix B
6.	be able to communicate, as a member of the IFSP team, the child's medical and health needs either directly or through the parent to the team	pp. 113-115, 148-150
7.	be able to help other members of the IFSP team understand the impact of those conditions on a child's overall development and implications of medical conditions for program planning	pp. 148-150
8.	assist the family in preparing for the IFSP development, providing support throughout the process, and encouraging the family to be heard and have a principal role in the IFSP development	pp. 97-98, 111-112, 148-150
9.	present and clarify information gained during assessment about the child's conditions, functional levels, family strengths and needs, in sufficient detail to be useful in the IFSP	pp. 134-135
10.	be able to function as the coordinator or liaison regarding child's health or medical needs, communicating with the child's case manager or other person representing the team providing early intervention services	pp. 168-170, 180-181

D.	TRANSITION	PAGE REFERENCES
	The primary care physician will:	
1.	understand the stress associated with transition from one service to another for the child and for the family	pp. 177-178

D.	TRANSITION (Continued)	PAGE REFERENCES
2.	be aware of community-based early intervention systems that may provide services for children leaving the hospital and returning home (see competencies related to child find and referral)	Appendix B
3.	be aware of the criteria which might lead to the termination of early intervention services and help the family become aware of the possibility of discharge from early intervention	pp. 182-185
4.	be aware of other services for children leaving early intervention programs and be able to provide information about services to families	pp. 182-185 Appendix B
5.	know how to make a referral to public schools for preschool special education services and know the criteria for eligibility	pp. 182-185 Appendix B
6.	know the advantages of integrated placements for children with disabilities, be aware of options for integrated placements, and be able to communicate that information to families	pp. 183-184, 189-192
7.	participate as a member of the team in developing plans for transition to be incorporated in the IFSP	pp. 178-179
8.	have communication skills needed to encourage and support families in developing plans for transition to be incorporated in the IFSP	pp. 178-179
9.	have communication skills needed to encourage and support families and children during the transition to services after early intervention	pp. 182-183, 188-192
10.	be aware of the need for and value of service coordination after early intervention	p. 186
11.	know other resources for service coordination in the community and provide that information to families	Appendix B

American Academy of Pediatrics (1988, Nov.). Proceedings From A National Conference on Public Law 99-457: Physician Participation in the Implementation of the Law. Washington, D.C.

APPENDIX C

Self-Study Manual Introductory Materials

CARING FOR INFANTS AND TODDLERS WITH DISABILITIES:

A SELF-STUDY MANUAL FOR PHYSICIANS

BY:

Patti Seklemian, M.A.
Francine G. Scott, M.Ed.
Corinne W. Garland, M.Ed.

Child Development Resources, Inc.

WITH CONSULTATION FROM:

Robert Boyle, M.D.
Susan Dilks, M.D.
University of Virginia Medical School

Child Development Resources P.O. Box 299 Lightfoot, VA 23090 August, 1993

ACCREDITATION STATEMENT

The University of Virginia School of Medicine designates this continuing medical education activity for 8 hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

The University of Virginia School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

This continuing medical education activity has been reviewed by the American academy of Pediatrics (AAP) and is acceptable for 8 AAP credit hours. These credits can be applied toward the PREP Education Award available to Fellows and Candidate Fellows of the American Academy of Pediatrics.

This program has been reviewed and is acceptable for 6 Prescribed hours by the AAFP. AAFP Prescribed credit is accepted by the AMA as equivalent to AMA PRA Category 1 for the AMA Physicians Recognition Award. When applying for the AMA PRA, Prescribed hours earned must be reported as Prescribed hours, not as Category 1.

Virginia Academy of Family Physicians

4211 Dover Road
Richmond, Virginia 23221

Phone (804) 358-1721

March 5, 1993

Dear Fellow Family Physician:

When I finished my family practice residency program in 1982, I thought I was ready to care for the needs of any child brought to my practice. Certainly I knew the right questions to ask and childhood exams were a part of my educational experience. There was, however, something missing.

My first twelve months of practice brought with it all the ups and downs of starting a practice, but other pieces of what my puzzle was missing began to surface. What was I to do when I saw my first infant with Down syndrome? How long did I watch little Johnny who at 15 months seemed uninterested in walking or 18 month old Susan whose speech was less intelligible than my 9 month old daughter?

The answers became evident as I attended the first meeting of my local early intervention agency . . . an agency dedicated to identifying children with handicaps at the earliest possible age to attempt to decrease or eradicate the effects of the possible handicap before school age. I realized that the past answers of previous decades of physicians were not appropriate. Simply saying that Johnny or Susie will grow out of their problems was only admitting my inadequacy of understanding and diagnosing the problem. In the end, I had to learn and be comfortable with the concept of early intervention and not allow school systems to inherit all the problems at school entry.

The next years meant a concentrated effort at attending meetings, reading literature and most importantly paying more detail to my evaluation of infants and small children. Needless to say, you can imagine my personal and professional pleasure when CDR invited Virginia's family physicians to join in support of a grant aimed at teaching Virginia's family physicians about how we can add knowledge about early intervention in caring for our patients.

I urge all of Virginia's family physicians to take advantage of this golden opportunity . . . learning how to be better physicians to the smallest of our patients. After all, even the smallest of our patients deserve the very best of our care.

Sincerely,

J Michael Ponder MD

J. Michael Ponder
Vice President
Virginia Academy of Family Physicians

Virginia Chapter
American Academy of Pediatrics

and The Virginia Pediatric Society

901 East Main Street
Suite 501
Richmond, Virginia 23219
804/643-8130
804/644-2502 Fax

Executive Committee:
President
Michael D. Dickens, M.D.
Vice-President
John W. Mitchell, Jr., M.D.
Secretary-Treasurer
W. Hugh Craft, Jr., M.D.
Past President
Melissa A. Young, M.D.
Delegate At Large
Douglas B. Gregory, M.D.
Nominating Committee
Ruth W. Campbell, M.D.
Program Committee
Beverley J. Bayes, M.D.
Advisors:
Raymond D. Adelman, M.D.
Harold M. Maurer, M.D.
Robert J. Roberts, M.D.
Executive Director
Betti G. Prentice, CAE

Council on Child and Adolescent Health:
Adolescence
Deborah E. Smith, M.D.
Bioethics Education
Edwin C. Myer, M.D.
Child Health Financing
Luthur A. Beazley, M.D.
Children With Disabilities
Susan A. Dilks, M.D.
Dependent Care
Viviana Skansi, M.D.
Fetus and Newborn
Robert W. Allen, Jr., M.D.
Hugh H. Wells, M.D.
Government Affairs
Robert M. Blizzard, M.D.
H. William Fink, M.D.
Hospital Care
Thomas J. Sullivan, M.D.
Injury and Poison Prevention
Margaret Dolan, M.D.
Membership
Julie C. Ellwood, M.D.
Practice and Ambulatory Care
Douglas B. Gregory, M.D.
Preventive Cardiology
Richard M. Schieken, M.D.
Public Information
Fredric N. Fink, M.D.
School Health
Joseph W. Familant, M.D.
Sports and Physical Fitness
Stephen P. Bolduc, M.D.
Substance Abuse
Walter L. Gilbert, M.D.
State Health Department Liaison
Joyce Linyear, M.D., M.P.H.

March 5, 1993

Dear Colleague:

The Virginia Chapter of the American Academy of Pediatrics is pleased to endorse this training project and the manual which has been developed by Child Development Resources (CDR). The manual is designed to assist pediatricians and family physicians in playing active roles in community-based early intervention services for children.

Virginia was fortunate in 1991 to be awarded a highly competitive grant from the U.S. Department of Education to fund the development of this training program, and this manual represents the culmination of over a year's effort by the staff of Child Development Resources to that end.

I hope that this manual will assist each of you in developing those skills necessary to become more effective advocates for children in this most important area.

Sincerely,

M.D. Dickens

Michael D. Dickens, M.D., F.A.A.P.
President
Virginia Chapter, American Academy of Pediatrics
Virginia Pediatric Society

BEST COPY AVAILABLE

PREFACE

Striking a balance between hope and realism is a challenge for those working with infants and their parents. Recently, I was asked to evaluate an infant with microcephaly (small head size) noted at birth. The baby's pediatrician followed her for well-child care for several months until it became clear that there were serious questions about vision and general development. Her parents were extremely anxious about the possibility of problems and refused further evaluation for many weeks after the pediatrician broached the subject. Finally, the parents agreed to a limited "second look" by a developmental pediatrician at a tertiary care center.

One look confirmed my suspicions based on the history I had received beforehand. Martha, now 4 months old, displayed little visual or auditory attention although she seemed to see and hear. She did not smile or interact socially, even though her parents were attentive and obviously attached to her. Her head circumference had changed little from birth.

During my interview, Martha's mother kept interjecting questions about things she might have done wrong during the pregnancy although her prenatal care and behavior were exemplary. My recommendations for further testing - magnetic resonance (MR) imaging of the brain, auditory brainstem evoked responses, electroencephalography, and ophthalmologic examination - were met with resistance, partly out of fear of possible harm and discomfort and partly out of fear of the results. It took several weeks for the parents to consent.

As expected, the MR study was abnormal, showing a failure of neurons to migrate completely to the cerebral cortex (lissencephaly). Furthermore, there was agenesis of the corpus callosum. The other tests were unremarkable.

I knew that the follow-up interpretive with Martha's parents was going to be difficult (i.e., emotionally charged). My intent was to refer them to genetics for counseling and to the community early intervention program. The more difficult task would be balancing hope and realism. Clearly, Martha would have serious developmental problems, but the exact extent could not be determined at this age.

Wolraich (1987) has written about communication of distressful information to parents. Several points he has made are useful for situations such as the one described above, whatever the setting:

- Allow parents to feel free to discuss concerns and feelings. Do not try to relieve guilt by statements such as "You shouldn't feel guilty because..." Professionals may acknowledge their own discomfort when conveying the information.

- Discuss possible reactions from other family members. It may be helpful to provide information to other supportive people, such as friends or close relatives, if the parents so desire.

- In the case of initial discussions, parents may not remember many of the details.

- Additional sessions or tape recordings are helpful.

- Terms such as cerebral palsy, pervasive developmental disorder, or developmental delay frequently are misunderstood. Carefully and repeatedly defining new words, using visual aids, pausing for reactions or questions, and providing written take-home materials can be useful.

- Rather than focusing on parents' acceptance of the child's condition, discussion should be directed toward what can be done to help. One pitfall is to imply that a permanent condition can be cured or will go away. Parents need to understand the limitations, as well as the potential benefits, of various medical, educational, therapeutic, and psychosocial interventions.

Martha's parents are now mulling over the referral to the early intervention program. I expect they will choose to engage these services in hopes of ameliorating, if not curing, Martha's problems. They seemed most relieved to hear that brain abnormalities are not fatal, and they continue to cling to the hope that their child's developmental problems will be minor. My writing of this preface has reinforced in my mind the need to communicate well with the early intervention program. The process of supporting Martha and her parents only began with my contact; in fact, communication of diagnosis is inevitably somewhat destructive. The most important work will continue in the community. By sharing what I have learned about Martha and her parents with the community service providers, the flow of support should continue and build without interruption.

-- James A. Blackman, M.D., M.P.H.

REFERENCE

Wolraich, M. (1987). General management techniques. In: M.L. Wolraich, (Ed.) The Practical Assessment and Management of Children with Disorders of Development and Learning. Chicago: Year Book Medical.

Reprinted with permission from James A. Blackman, "From the Editor" in Infants and Young Children, Vol. 5:2, with permission of Aspen Publishers, Inc., © 1992.

TABLE OF CONTENTS

SECTION NUMBER & TITLE		PAGE NUMBER
1.	EARLY INTERVENTION	1
2.	OVERVIEW OF PROJECT	12
3.	PHILOSOPHICAL FOUNDATIONS	21
4.	LEGISLATIVE HISTORY	39
5.	VIRGINIA PART H SYSTEM	47
6.	CHILD FIND	59
7.	CHILD EVALUATION AND ASSESSMENT	94
8.	IDENTIFICATION OF FAMILY RESOURCES, PRIORITIES, AND CONCERNS	130
9.	IFSP AND SERVICE COORDINATION	144
10.	TRANSITION	176
APPENDICES		194
11.	A: Competencies on Which Curriculum is Based and Page References to Corresponding Sections of the Manual	195
12.	B: Directory of Local Service Providers	196
13.	C: State and National Resources	197
14.	D: Virginia Part H Service Delivery Policies	198
15.	E: Definition of Developmental Delay in Other States	199

APPENDIX D

Evaluation Instrumentation

- **Pre-Knowledge Measure**
- **Pre-Competency Measure**
- **Self-Study Manual and Audiotapes Evaluation**
- **Introductory Seminar Evaluation**

Region _____ Date_____

CARING FOR INFANTS AND TODDLERS WITH DISABILITIES: NEW ROLES FOR PHYSICIANS

Physician Knowledge Measure/Pre-Test

For each multiple choice question/statement, please circle the best answer.

1. Which of the following activities might be considered part of the child find effort for early intervention?
   1. developmental screening provided in physicians' offices
   2. developmental screening provided by early intervention program personnel
   3. public service television announcements about early intervention services
   4. a multidisciplinary team evaluation

   a) 1 **c) 1, 2, and 4**
   b) 1 and 2 **d) all of the above**

2. Periodic developmental screening using a formal screening instrument is:
   1. a standard of health care for infants and toddlers
   2. an ideal that busy physicians should try to work into their office routines
   3. recommended every 6 months
   4. recommended at birth; 2, 4, 6, 9, 12, 15, and 18 months; and then annually until 6 years

   a) 1 **c) 2**
   b) 1 and 3 **d) 1 and 4**

3. When screening results indicate the need for a further evaluation, physicians should help families consider the following options:
   1. wait until the next routinely scheduled screening
   2. refer the child for a full developmental evaluation
   3. refer the child for developmental monitoring by an early intervention program
   4. make other referrals the family might need

   a) 1 **c) 3**
   b) 2 **d) all of the above**

4. In determining whether or not a child should be referred for a further evaluation, a physician should consider:
   1. screening results
   2. observation
   3. medical history
   4. parent preference

   a) 1 **c) 1 and 3**
   b) 1, 2, and 3 **d) all of the above**

5. When a child has a clearly identified disability, the following steps are necessary before early intervention services can begin:
   1. screening by a physician or other professional
   2. a multidisciplinary team evaluation
   3. referral to the early intervention team serving the community in which the family lives

   a) 2 **c) 3**
   b) 1 and 2 **d) all of the above**

6. When a parent and professional agree that a referral for an evaluation and assessment are needed, which of the following are true:
   1. the referral must be accompanied by a diagnosis
   2. the referral should, with parent permission, be accompanied with all necessary medical information
   3. the referral must be made within two working days
   4. the family must have health insurance or another form of payment for the evaluation

   a) 1 and 4 **c) 2 and 3**
   b) 2 **d) 2 and 4**

7. In the context of early intervention, which of the following are true:
   1. an evaluation by the early intervention team is always needed to determine a child's eligibility for early intervention services
   2. early intervention services may begin without an evaluation for children who have a clearly identified disability or condition known to result in developmental delay
   3. a multidisciplinary evaluation team need only to include professionals from two or more disciplines
   4. evaluation and assessment must be provided by a team involving professionals from two or more disciplines and the family

   a) 1 **c) 2 and 4**
   b) 1 and 4 **d) 1 and 3**

8. Once a physician has referred a child to early intervention, which of the following are true:
   1. the physician has an important role in assessment that includes,with family permission, sharing medical information
   2 the physician can, with parent permission, consult with the team by phone or can attend the assessment
   3. a description of the child's current health status, vision, and hearing are required components of the early intervention team assessment
   4. other team members do not need and will not understand information about medications or medical history

   a) 1 **c) 1, 2, and 3**
   b) 1 and 2 **d) 4**

9. In the context of early intervention, which of the following are true about the multidisciplinary team assessment:
   1. a major purpose of the assessment is to answer questions the family has about their child's development
   2. the family has an important role in deciding who needs to be on the assessment team
   3. the assessment results are the basis for early intervention services to be provided
   4. the assessment results and family concerns, resources, and priorities are the basis for the early intervention services to be provided

   a) 1 and 4 **c) 3 and 4**
   b) 1 and 3 **d) 1, 2, and 4**

10. An Individualized Family Service Plan is:
    1. a written plan that is required by law and that is a statement of the goals of early intervention, the services to be provided, and the outcomes to be accomplished
    2. a legal document that belongs to the early intervention system
    3. a family-owned plan, developed with and for the family and shared only with their permission
    4. a plan that should, with parent permission, be monitored by the physician and changed by the team in response to the health and medial status of the child

    a) 1 and 4 **c) 1, 3, and 4**
    b) 1, 2, and 4 **d) 3 and 4**

11. The physician's role in the IFSP process includes which of the following?
    1. helping families identify their concerns, priorities, and resources
    2. sharing information with the family and, with permission, with other team members about health-related issues that should be addressed in the plan
    3. helping families identify services they might need
    4. with family permission, reviewing the plan to ensure that health-related issues are adequately addressed

    a) 1 and 2 **c) 2, 3, and 4**
    b) 2 and 3 **d) all of the above**

12. Service coordination in the context of early intervention is:
    1. the same as health care coordination and the physician's responsibility
    2. a continuous process of linking and monitoring early intervention services that are included in the IFSP
    3. provided without cost to families
    4. provided by a temporary service coordinator at the time of referral

    a) 1 **c) 2 and 4**
    b) 2 **d) 2, 3, and 4**

13. During transitions or discharge planning, a physician can be especially helpful to a family by:
    1. giving them lots of reading materials
    2. giving families the information they need to consider next placements
    3. helping families decide whether the health-related services proposed for the next placement are adequate and appropriate
    4. making timely referrals of children newly discharged from hospital settings to community-based early intervention services

    a) all of the above **c) 3 and 4**
    b) 2, 3, and 4 **d) 4**

14. A child may receive public school early childhood special education services if:
    1. the child is age two by September 30th of the school year
    2. the child is determined eligible by a public school eligibility committee
    3. the child continues to be developmentally delayed
    4. the child's parent wishes

    a) 1 and 2 **c) 2**
    b) 1 and 3 **d) 1, 2, and 4**

15. If a child is eligible for public school early childhood special education and related services, those services:
    1. must be specified in a written Individualized Educational Plan
    2. must be provided in a special class for children with disabilities
    3. may be provided in a day care, preschool, or Head Start Program
    4. must be based on individual child needs

    a) 1 **c) 1 and 3**
    b) 2 and 4 **d) 1, 3, and 4**

THANK YOU!

CARING FOR INFANTS AND TODDLERS WITH DISABILITIES: NEW ROLES FOR PHYSICIANS

Physician Competency Measure/Pre-Test

Many of the competencies below are new roles for physicians. Please indicate your level of competency in each area using the rating scale described below.

RATING SCALE:

Please rate the extent to which you believe you have mastered each of the following competencies by circling your choice.

1 = I need a great deal more information or training
3 = I need some more information or training
5 = I have full mastery

A.	CHILD FIND	Level of Competency
1.	displaying an awareness of the importance of developmental and family issues (p. 24)	1 2 3 4 5
2.	knowing the components and intent of P.L. 99-457 and the policies and procedures of their state relative to screening, identification, and referral of children to Part H services (pp. 39-42, 45-53)	1 2 3 4 5
3.	knowing the criteria for eligibility within your state for Part H services (pp. 50-51, 91-92)	1 2 3 4 5
4.	being able to identify factors placing a child at-risk for developmental delay with particular emphasis on those factors making a child eligible for Part H services (pp. 59-68)	1 2 3 4 5
5.	having and regularly employing strategies in a variety of settings (e.g., newborn nursery, hospital stays, well-child office visits) to observe and identify children who have disabilities, developmental delays, or who may be at-risk for delay (pp. 65-66)	1 2 3 4 5
6.	being skilled in the use and interpretation of developmental screening techniques (pp. 65-66)	1 2 3 4 5

A.	CHILD FIND (cont'd.)	Level of Competency
7.	having a strategy for providing periodic screening in the context of office-based primary care including: (pp. 58-68) • developmental screening of all infants • periodic rescreening for all children	 1 2 3 4 5 1 2 3 4 5
8.	knowing and using the procedures for referring infants and toddlers to the Part H services within the community, and knowing the variety of community resources available for infants and toddlers who may be eligible (pp. 69-74, Appendix B)	1 2 3 4 5
9.	having and regularly using a variety of strategies to enhance linkages and coordination of care including making and receiving referrals to and from secondary tertiary care settings, risk registries, and other relevant consultants (pp. 71-75)	1 2 3 4 5
10.	having and regularly using a variety of strategies for increasing family awareness of developmental milestones, resources for assessment, the importance of early identification, and potential for improved outcomes (pp. 68-71)	1 2 3 4 5
11.	having and regularly using a variety of formal and informal interview techniques to elicit family concerns and observations regarding the development of their infants and toddlers (pp. 68-71)	1 2 3 4 5
12.	having and using communication skills and strategies appropriate for ensuring family understanding of medical information, including consultant findings, and for ensuring their involvement in decisions about referral to Part H or further evaluation and intervention (pp. 68-69, 89-91)	1 2 3 4 5
13.	having strategies and routines for the acquisition of new state-of-the-art knowledge base related to this area (p. 84-85, toll-free number)	1 2 3 4 5
B.	ASSESSMENT	
1.	being aware of options for your own involvement in assessment, diagnosis, and management of the child's health needs based on interests and skills, and being able to communicate clearly that degree of involvement to parents or caregivers (pp. 95-96)	1 2 3 4 5

B. ASSESSMENT (cont'd.)		Level of Comptency
2.	being skilled in interpreting diagnostic information and implications of diagnosis with family, including eliciting their ideas and concerns (pp. 91-92, 106-108)	1 2 3 4 5
3.	knowing and using resources for obtaining consultation from other Part H providers necessary and being skilled in presenting the need and rationale for consultation to family (Appendix B)	1 2 3 4 5
4.	being able to interpret all findings for the family in an understandable way and involving and supporting family in decisions related to additional assessement, referral, and intervention (pp. 103-107)	1 2 3 4 5
5.	being able to perform longitudinal monitoring of a child to clarify trends of growth or function, when appropriate (pp. 92-96)	1 2 3 4 5
6.	being able to provide family with options for referral and making appropriate referrals to agencies providing needed services (pp. 71-75)	1 2 3 4 5
7.	being able to present information related to the child's medical condition and functional level to familiy and other team members responsible for development of a plan of intervention (pp. 95-96)	1 2 3 4 5
8.	being skilled in formal and informal interview techniques to allow families to share their strengths and needs related to their child's development and providing emotional support in the process (pp. 89-90, 97-99)	1 2 3 4 5
9.	being skilled in formal and informal interview techniques that encourage families to share their own perceptions of their child's problems, strengths, and needs, and that help families clarify those perceptions (pp. 103-104, 106-108, 127-128)	1 2 3 4 5
10.	being aware of community resources and having skills in helping families obtain the services they desire (Appendix B)	1 2 3 4 5
C.	DEVELOPING/IMPLEMENTING IFSPs	
1.	being aware of P.L. 99-457 and of principles of family-centered intervention plans (pp. 21-23, 39-42, 134)	1 2 3 4 5

C.	DEVELOPING/IMPLEMENTING IFSPs (cont'd.)	Level of Competency
2.	being able to define and arrange medical consultations required for the child's assessment, diagnosis, and ongoing management in a manner consistent with the self-selected degree of involvement and to maintain communication with consultant (pp. 137-138, 158-159)	1 2 3 4 5
3.	knowing and being able to discuss with a family the value of an IFSP, and knowing how to initiate or help a family initiate a group process to begin IFSP development (pp.134-137)	1 2 3 4 5
4.	assisting a family in determining who should be involved in the IFSP process (pp. 134-137)	1 2 3 4 5
5.	knowing the procedure for referral to local early intervention service provider(s) responsible for IFSP development and helping a family in arranging for their participation (pp. 69-74)	1 2 3 4 5
6.	being able to communicate, as a member of the IFSP team, the child's medical and health needs either directly or through the parent to the team (pp. 106-107, 138-139)	1 2 3 4 5
7.	being able to help other members of the IFSP team understand the impact of those conditions on a child's overall development and implications of medical conditions for program planning (pp. 124-129)	1 2 3 4 5
8.	assisting the family in preparing for the IFSP development, providing support throughout the process, and encouraging the family to be heard and have a principal role in the IFSP development (pp. 124-129)	1 2 3 4 5
9.	presenting and clarifying information gained during assessment about the child's conditions, functional levels, and family strengths and needs in sufficient detail to be useful in the IFSP (pp. 124-129)	1 2 3 4 5
10.	being able to function as the coordinator or liaison regarding a child's health or medical needs, communicating with the child's case manager or other person representing the team providing early intervention services (pp. 157-161)	1 2 3 4 5

D.	TRANSITION	Level of Competency
1.	understanding the stress associated with transition from one service to another for the child and for the family (pp. 165-166)	1 2 3 4 5
2.	being aware of community-based early intervention systems that may provide services for children leaving the hospital and returning (see competencies related to child find and referral) (Appendix B)	1 2 3 4 5
3.	being aware of the criteria which might lead to the termination of early intervention services and helping the family become aware of the possibility of discharge from early intervention (pp. 69-75)	1 2 3 4 5
4.	being aware of other services for children leaving early intervention programs and being able to provide information about services to families (pp. 69-75, Appendix B)	1 2 3 4 5
5.	knowing how to make a referral to public schools for preschool special education services and knowing the criteria for eligibility (pp. 170-172)	1 2 3 4 5
6.	knowing the advantages of integrated placements for children with disabilities, being aware of options for integrated placements, and being able to communicate that information to families (p. 171)	1 2 3 4 5
7.	participating as a member of the team in developing plans for transition to be incorporated in the IFSP (pp. 166-169)	1 2 3 4 5
8.	having communication skills needed to encourage and support families in developing plans for transition to be incorporated in the IFSP (pp. 166-169)	1 2 3 4 5
9.	having communication skills needed to encourage and support families and children during the transition to services after early intervention (pp. 170-172)	1 2 3 4 5
10.	being aware of the need for and value of service coordination after early intervention (p. 173)	1 2 3 4 5
11.	knowing other resources for service coordination in the community and providing that information to families (Appendix B)	1 2 3 4 5

THANK YOU!

CARING FOR INFANTS AND TODDLERS WITH DISABILITIES: NEW ROLES FOR PHYSICIANS

EVALUATION

Self-Study Manual and Audiotapes for Physicians

REGION: DATE:

Thank you for taking a moment to evaluate the self-study manual and audio- tapes. Your feedback and comments will be used to document the effectiveness of this component of the curriculum.

Rating scale for questions 1 through 3 (please circle your response):
1 = Poor 3 = Good 5 = Excellent

1.	Organization of manual	1	2	3	4	5
2.	The format of the manual	1	2	3	4	5
3.	Readability of the content	1	2	3	4	5

Rating scale for questions 4 through 7 (please circle your response):
1 = Not at All 3 = Somewhat 5 = Fully

4.	Extent to which information was clear	1	2	3	4	5
5.	Usefulness of information	1	2	3	4	5
6.	Extent to which the self study portion of the curriculum met your expectations	1	2	3	4	5
7.	Extent to which the audio tapes were helpful	1	2	3	4	5

8. Did you complete the entire manual?
_____ yes
_____ no

9. If you answered "no" to question 8, which sections did you complete? _____
_____
_____

10. How would you recommend improving the manual? _____
_____

11. Would you recommend this self-study manual and audiotapes to a colleague?
    _____ yes
    _____ no

12. I am a:
    _____ pediatrician
    _____ family physician
    _____ other (please specify) _____

13. Please provide any additional comments regarding the self-study manual and/or audiotapes.

_____

_____

_____

THANK YOU!

Region_____ Date_____

CARING FOR INFANTS AND TODDLERS WITH DISABILITIES: NEW ROLES FOR PHYSICIANS

INTRODUCTORY SEMINAR EVALUATION

Please complete and return this evaluation to the registration desk. Your feedback is important for planning future programs.

Rating scale for questions 1 through 3 (please circle your response):
1 = poor **3 = good** **5 = excellent**

1.	Coordination of pre-registration process	1	2	3	4	5
2.	Effectiveness of audiovisual materials	1	2	3	4	5
3.	Presenters' knowledge of the subject	1	2	3	4	5

Rating scale for questions 4 through 7 (please circle your response):
1 = not at all **3 = somewhat** **5 = fully**

4.	Extent to which information was clear	1	2	3	4	5
5.	Usefulness of information presented	1	2	3	4	5
6.	Extent to which the training objectives were met	1	2	3	4	5
7.	Extent to which the training met your expectations	1	2	3	4	5

7a. If not, please explain: _____
_____
_____

8. What information presented will be the most useful to you? _____
_____
_____

9. What information will be the least useful to you? _____
_____
_____

- over -

10. How do you feel the training can be improved? _____
_____
_____

11. What was not covered that you would have liked information about? _____
_____
_____

12. Please share any additional comments or suggestions: _____
_____
_____

13. Are you a:
_____ pediatrician _____ family physician
_____ other (please specify) _____

14. If you are a pediatrician, does your practice include:
_____ general pediatrics only
_____ specialty pediatrics only
_____ both

15. How did you first hear about **Caring for Infants and Toddlers with Disabilities: New Roles for Physicians** continuing medical education project?
_____ a project brochure
_____ a parent of a patient
_____ a letter from the project or Academy
_____ newsletter article
_____ a colleague
_____ other (please specify) _____

THANK YOU!